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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15497

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

15497

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Elk Mills ELKTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELK MILLS	
c. LENGTH OF STAY IN 1b Life		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital of Cecil County		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Brooks Allen		4. DATE OF DEATH Month 11 Day 14 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/21/83
9. AGE (In years at Birthday) 85 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONT. FIBRE		11b. KIND OF BUSINESS OR INDUSTRY LABOR	
11. BIRTHPLACE (County & State, or foreign country) Chesapeake City, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Allen		14. MOTHER'S MAIDEN NAME Josephine CORNELIA PALLEN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Ella May Allen, Same		Address ELK MILLS Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Acute Cardiac Failure DUE TO (b) Acute Coronary disease with infarction DUE TO (c) Cerebral Accident		INTERVAL BETWEEN ONSET AND DEATH 1-Day 2-Months 2-Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 11/11/66, 19 66, to 11/14/66, that (I) (we) last saw the deceased alive on 11/14/66, and that death occurred at 8:PM, from the causes and on the date stated above.			
22a. SIGNATURE James L. Johnson		22b. DATE SIGNED 11/15/66	
22c. PHYSICIAN'S NAME (Type) James L. Johnson M.D.		22d. ADDRESS 245 East High St., Elkton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/17/66	
23c. NAME OF CEMETERY OR CREMATORY CHERRY HILL CEM.		23d. LOCATION (City, town or county) (State) CHERRY HILL, Md.	
24. FUNERAL DIRECTOR PIPPIN FUNERAL HOME Donald M. Pippin Md		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE NOV 17 1966			

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<div style="display: flex; justify-content: space-between;"> <div> <p>15498</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>15498</p> </div> </div>															
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Cecil</u> MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u></p> <p>c. LENGTH OF STAY IN 1b <u>2 years</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Devine Nursing Home</u></p>					<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u></p> <p>d. STREET ADDRESS <u>071</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>										
<p>3. NAME OF DECEASED (Type or print) First Middle Last <u>Esther E. Ansalvish</u></p>					<p>4. DATE OF DEATH Month Day Year <u>November 30, 1966</u></p>										
<p>5. SEX <u>Female</u></p>		<p>6. COLOR OR RACE <u>Cau.</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>Nov. 9, 1889</u></p>		<p>9. AGE (In years last birthday) <u>77</u> yrs.</p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u></p>		<p>11. BIRTHPLACE (County &amp; State, or foreign country) <u>Penna.</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>	
<p>13. FATHER'S NAME <u>John T. Tweed</u></p>					<p>14. MOTHER'S MAIDEN NAME <u>Mary E. Wright</u></p>										
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u></p>		<p>16. SOCIAL SECURITY NO. <u>None</u></p>		<p>17. INFORMANT Address <u>Mrs. Mary Leeflang, Perryville, Md.</u></p>											
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Series of strokes</u></p> <p><u>422.1</u> DUE TO <u>Arteriosclerotic cardiovascular disease</u></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Unknown</u></p> <p>(c)</p>												<p>INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u></p>			
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>														<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>											
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u></p>				<p>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work</p>				<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>				<p>20f. (City or town) (County) (State)</p>			
<p>21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 28, 1966</u>, to <u>Nov. 30, 1966</u>, that (I) (we) last saw the deceased alive on <u>Nov. 30, 1966</u>, and that death occurred at <u>12:00</u> M, from the causes and on the date stated above.</p>															
<p>22a. SIGNATURE <u>S. Ralph Andrews, Jr.</u></p>												<p>22b. DATE SIGNED <u>Nov. 30, 1966</u></p>			
<p>22c. PHYSICIAN'S NAME (Type) <u>S. RALPH ANDREWS, JR. M.D.</u></p>												<p>22d. ADDRESS <u>Elkton, Maryland</u></p>			
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>				<p>23b. DATE THEREOF <u>12/3/1966</u></p>				<p>23c. NAME OF CEMETERY OR CREMATORY <u>Spesucia Cemetery</u></p>				<p>23d. LOCATION (City, town or county) (State) <u>Perryman, Harford, Md</u></p>			
<p>24. FUNERAL DIRECTOR <u>Lee A. Patterson &amp; Son</u> ADDRESS <u>Perryville, Md.</u></p>												<p>25a. REC'D BY REGISTRAR <u>Charles Judge</u></p>		<p>25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u></p>	
<p>DATE <u>DEC 7 1966</u></p>															

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
15499					15499						
1. PLACE OF DEATH a. COUNTY Cecil					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital					d. STREET ADDRESS Walnut Lane						
3. NAME OF DECEASED (Type or print) BARRY					4. DATE OF DEATH 11-24-66						
5. SEX Male					6. COLOR OR RACE White						
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					8. DATE OF BIRTH Feb. 23, 1874						
9. AGE (In years last birthday) 92 yrs.					10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.						
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship Building					11. BIRTHPLACE (County & State, or foreign country) Maryland						
12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME Jacob M. Biddle						
14. MOTHER'S MAIDEN NAME Elizabeth E. Jones					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes						
16. SOCIAL SECURITY NO. Spanish-Amer.					17. INFORMANT Mrs. Jacob T. Biddle, Elkton, Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 490X IMMEDIATE CAUSE (a) <u>Lobar pneumonia Bilateral</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 18 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work						
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from Nov 6, 1966, to Nov 24, 1966, that (I) (we) last saw the deceased alive on Nov 23, 1966, and that death occurred at 7 AM, from the causes and on the date stated above.											
22a. SIGNATURE Henry V. Davis										22b. DATE SIGNED 11/25/66	
22c. PHYSICIAN'S NAME (Type) Henry V. Davis										22d. ADDRESS Chesapeake City, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 11/26/66		23c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery				
23d. LOCATION (City, town or county) (State) Elkton, Md.					25a. REC'D BY REGISTRAR DATE DEC 7 1966						
24. FUNERAL DIRECTOR Ralph E. Hicks					25b. REGISTRAR'S SIGNATURE Charles Judge						

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15500

## CERTIFICATE OF DEATH

15500

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bainbridge</u>		c. LENGTH OF STAY IN 1b <u>3 hrs. 25 min.</u> <u>Port Deposit</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Station Hospital, USNTC</u>		d. STREET ADDRESS <u>R.D. #1</u>	
3. NAME OF DECEASED (Type or print) <u>(Child not named)</u>		4. DATE OF DEATH Month <u>November</u> Day <u>14</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 14, 1966</u>
9. AGE (In years last birthday) yrs. <u>3</u>		IF UNDER 1 YEAR Months <u>07</u> Days <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-----</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Cecil County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown (None given)</u>		14. MOTHER'S MAIDEN NAME <u>Janet Marie BUCK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>-----</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>-----</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY DISTRESS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>PREMATURITY</u> DUE TO (c) <u>PREMATURE LABOR</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>3 HRS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>-----</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>-----</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>	20f. (City or town) (County) (State) <u>-----</u>
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>14 Nov. 1966</u> , to <u>14 Nov. 1966</u> that (I) <u>last</u> saw the deceased alive on <u>14 Nov. 1966</u> , and that death occurred at <u>5:13 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>11/14/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>WINDHAM BREMER LT MC USNR</u>		22d. ADDRESS <u>Station Hospital, USNTC, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>14 November 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Coloma Cecil Md.</u>
24. FUNERAL DIRECTOR <u>LEE A. PATTERSON &amp; SON, PERRYVILLE, MD.</u>		25a. REC'D BY REGISTRAR <u>NOV 16 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

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JAN 10 1964  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C.



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN lb <b>2 weeks</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Union Hospital</b>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>North East</b> 07/	
f. STREET ADDRESS <b>6 Beech St.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GETTA</b> Middle <b>ANN</b> Last <b>CAMERON</b>		4. DATE OF DEATH Month <b>November</b> Day <b>17</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 25, 1895</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Cecil Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph H. DeMonde</b>		14. MOTHER'S MAIDEN NAME <b>Suzanne M. Hamilton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Omar H. Cameron</b>		Address <b>R.D. 2 North East, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetic Acidosis</b> 260X DUE TO (b) <b>Diabetes Mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Atherosclerosis; Ischemia of Labyrinth, left; Nephrosclerosis; Hiatus Hernia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b> <b>5 years</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan.</b> , 19 <b>47</b> , to <b>17 Nov.</b> , 19 <b>66</b> , that (II) (we) last saw the deceased alive on <b>17 Nov.</b> , 19 <b>66</b> , and that death occurred at <b>8:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Klaus H. Huebner</b>		22b. DATE SIGNED <b>11/17/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>KLAUS H. HUEBNER M.D.</b>		22d. ADDRESS <b>NORTH EAST, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/20/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>North East Methodist</b>		23d. LOCATION (City, town or county) (State) <b>North East Cecil Co. Md.</b>	
24. FUNERAL DIRECTOR <b>Grant Funeral Home</b>		25a. REC'D BY REGISTRAR <b>NOV 21 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. ADDRESS <b>North East, Md.</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**15502****CERTIFICATE OF DEATH****15502**

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton.</b>				c. LENGTH OF STAY IN 1b <b>Cecilton.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital.</b>				d. STREET ADDRESS <b>071</b>			
3. NAME OF DECEASED (Type or print) First <b>MARTHA</b> Middle <b>ELIZABETH</b> Last <b>CANNAN</b>				4. DATE OF DEATH Month <b>November</b> Day <b>17</b> Year <b>19 66</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October, 12, 1875</b>		9. AGE (In years last birthday) <b>91</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Albert Cannan</b>				14. MOTHER'S MAIDEN NAME <b>Hester Ann Blackway.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>Joseph Short,</b>		17. INFORMANT Address <b>Cecilton, Md. 21913</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Atraumatism fracture of right hip (pathologic due to osteoporosis)</b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5 Nov</b> , 19 <b>66</b> , to <b>17 Nov</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>17 Nov</b> 19 <b>66</b> , and that death occurred at <b>11:50 AM</b> causes and on the date stated above.							
22a. SIGNATURE <i>Wallace O. Enshain</i>				22b. DATE SIGNED <b>18 Nov 66</b>		22c. PHYSICIAN'S NAME (Type) <b>Wallace O. Enshain, M.D.</b>	
22d. ADDRESS <b>Cecilton, Md.</b>				22e. ADDRESS <b>Cecilton, Md.</b>		22f. ADDRESS <b>Cecilton, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 19, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cecilton Cemetery.</b>		23d. LOCATION (City, town or county) (State) <b>Cecilton, Cecil Co; Md.</b>	
24. FUNERAL DIRECTOR <b>Edward Fellows.</b>				25a. REC'D BY REGISTRAR <b>NOV 21 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



15503

## CERTIFICATE OF DEATH

Reg. Dist. No.

15503

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Penna.</b> b. COUNTY <b>Chester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Calvert</b>		c. LENGTH OF STAY IN 1b <b>3Months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Calvert Manor Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mrs Anna</b> Middle <b>May</b> Last <b>Chase</b>		4. DATE OF DEATH Month <b>November</b> Day <b>23,</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 23, 1869</b>
9. AGE (In years last birthday) yrs. <b>97</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Titusville, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Julius Lovell</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Dowlerr</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>E. Harvey Chase-Lincoln University #1 Pa.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac decompensation</b> DUE TO <b>arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>5 days</b> (c) <b>5 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>diabetes mellitus</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> 19 <b>61</b> , to <b>11-22</b> , 19 <b>66</b> that I last saw the deceased alive on <b>11-22</b> , 19 <b>66</b> , and that death occurred at <b>12:50 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Rising Sun, Md</b> DATE SIGNED <b>11-24-66</b>			
ACTUAL SIGNATURE <b>Neil R Taylor</b> M.D.		PHYSICIAN'S NAME (Type) <b>Neil R Taylor</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/25/1966</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Union Lancaster Co. Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Comon E. Mullen</b>		24. REC'D BY REGISTRAR <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15502

CERTIFICATE OF DEATH

15502

Blank form with faint lines and text, including a large handwritten '7' in the center.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15504

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15504

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit</b>			c. LENGTH OF STAY IN 1b <i>Since 1940</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit</b> <i>07-1</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>23 Race Street</b>				d. STREET ADDRESS <b>23 Race Street</b>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>SEYMORE</b> Last <b>CLARK</b>				4. DATE OF DEATH Month <b>11</b> Day <b>7</b> Year <b>19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 17, 1924</b>		9. AGE (In years last birthday) yrs. <b>41</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>7</b> Hours <b>19</b> Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mess Attendant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>A. P. Ground</b>		11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Seymore Clark</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Carter</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>226-26-0975</b>		17. INFORMANT <b>Mrs. Virginia H. Brown, Port Deposit, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Fatty Metamorphosis of Liver</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Rudiger Breiteneker</b> EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED <b>11/7/66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<b>Burial</b>		<b>Nov. 10, 1966</b>		<b>First Baptist Cemetery</b>		<b>Cokestown, Cecil, Md.</b>	
24. FUNERAL DIRECTOR <b>Otelia J. Bullock, Harre de Dracy, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 9 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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STATE OF TEXAS

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BP

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15505

CERTIFICATE OF DEATH

15505

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Elkton</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Union Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cecilton.</b> d. STREET ADDRESS <b>07.1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <del>GOODE</del> ALVIN <del>ROBERTSON</del> H. COXE		4. DATE OF DEATH Month Day Year <b>11 30 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 29, 1917</b>
9. AGE (In years last birthday) <b>49</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <b>11 30 19 66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman, Gen. Construction. Building Const.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Heston Coxe.</b>		14. MOTHER'S MAIDEN NAME <b>Etta Dickerson.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>217-09-4880</b>	
17. INFORMANT (Cecelia) <b>Mrs. Catherine Coxe,</b>		Address <b>Cecilton, Md. 21913</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>STOMACH</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11/1</b> , 19 <b>66</b> , to <b>11/30</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>11/30</b> , 19 <b>66</b> , and that death occurred at <b>223P</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>John A. Fischer</b>		22b. DATE SIGNED <b>12/1/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>John A. Fischer</b>		22d. ADDRESS <b>ELKTON, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial.</b>		23b. DATE THEREOF <b>Dec. 3, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Chester Cemetery.</b>		23d. LOCATION (City, town or county) (State) <b>Chestertown, Kent Co; Md.</b>	
24. FUNERAL DIRECTOR <b>Edward Fellows.</b>		25a. REC'D BY REGISTRAR <b>DEC 5 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>gcharles judge</b>			

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Union Local

James M. ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15506

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15506

1. PLACE OF DEATH a. COUNTY <u>Decit</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Decit</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>North East</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>		d. STREET ADDRESS <u>Rt #1- Box 112</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marion G. Denny</u>		4. DATE OF DEATH Month Day Year <u>Nov 18 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/21/1898</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charlie Gerry</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Osborn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>252-12-6487A</u>	
17. INFORMANT <u>North East rd.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute myocardial infarction</u> DUE TO (c) <u>ASCVD.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) this hospital attended the deceased from <u>11-18</u> , 19 <u>66</u> , to <u>11-18</u> , 19 <u>66</u> , that (2) (we) last saw the deceased alive on <u>11-18</u> , 19 <u>66</u> , and that death occurred at <u>4 p</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. J. Bannant</u>		22b. DATE SIGNED <u>11-28-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Bannant</u>		22d. ADDRESS <u>North East, Decit Co. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>11/21/1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Harlow Memorial Gds.</u>		23d. LOCATION (City or Town) (County) (State) <u>Chesapeake, St. Mary's Md.</u>	
24. FUNERAL DIRECTOR <u>Walter Macaulay &amp; Son, Funeral Home</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 2 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

15508

STATEMENT OF DEATH

15508

Name: *Charles Henry*  
 Sex: *Male*  
 Date of Birth: *10/1/1888*  
 Place of Birth: *St. Louis, Mo.*  
 Date of Death: *11-1-1958*  
 Cause of Death: *Heart Failure*  
 Place of Death: *St. Louis, Mo.*  
 Burial Place: *St. Louis, Mo.*  
 Name of Burial Place: *St. Louis, Mo.*  
 Name of Informant: *St. Louis, Mo.*  
 Address of Informant: *St. Louis, Mo.*  
 Signature: *St. Louis, Mo.*  
 Date: *11-1-1958*

Name: *Charles Henry*  
 Sex: *Male*  
 Date of Birth: *10/1/1888*  
 Place of Birth: *St. Louis, Mo.*  
 Date of Death: *11-1-1958*  
 Cause of Death: *Heart Failure*  
 Place of Death: *St. Louis, Mo.*  
 Burial Place: *St. Louis, Mo.*  
 Name of Burial Place: *St. Louis, Mo.*  
 Name of Informant: *St. Louis, Mo.*  
 Address of Informant: *St. Louis, Mo.*  
 Signature: *St. Louis, Mo.*  
 Date: *11-1-1958*



**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 15507

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Cecil		MARYLAND		STATE Maryland		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Elkton		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Elkton			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Union Hospital				STREET ADDRESS (If rural give location) Barksdale Road R.D. #4			
3. NAME OF DECEASED (Type or Print) Leona A. Dever				4. DATE OF DEATH (Month) (Day) (Year) Nov. 19, 19 66			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH May 19, 1892	9. AGE last birthday 74 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Adv. Dept. DuPont			10b. KIND OF BUSINESS OR INDUSTRY Delaware	11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Crothers				14. MOTHER'S MAIDEN NAME Leona Lister			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mr. William T. Dever (Same)			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) ACUTE ANTERIOR MYOCARDIAL INFARCTION						INTERVAL BETWEEN ONSET AND DEATH 12 hours	
ANTECEDENT CAUSE(S) DUE TO (B) ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. MILD ADULT DIABETES MELLITUS							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. et work <input type="checkbox"/> Not while et work <input type="checkbox"/>		21e. INJURY OCCURRED While et work <input type="checkbox"/> Not while et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept. 19 65, to 19 Nov, 19 66, that I last saw the deceased alive on 19 Nov, 19 66, and that death occurred at 8:05 P.M. from the causes and on the date stated above.							
SIGNATURE Robert J. Gray				ADDRESS (Street, city, town, state) DATE SIGNED M.D. ELKTON MEDICAL PARK ELKTON 11/23/66			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 11/23/66		NAME OF CEMETERY OR CREMATORY Lawncroft Cemetery		LOCATION (City, town, or county) (State) Linwood, Pennsylvania	
24. REC'D BY REGISTRAR DATE NOV 29 1966		REGISTRAR'S SIGNATURE Charles Judge		25. FUNERAL DIRECTOR'S SIGNATURE Albert J. McGraw Jr.		ADDRESS Wilm., Del. 2700 Wash. St.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15508

CERTIFICATE OF DEATH

15508

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>59 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
f. STREET ADDRESS <b>3125 Mt. Pleasant St., N.W.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>PETER EDWARD DURST</b>		4. DATE OF DEATH Month Day Year <b>November 17 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-27-00</b>
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <b>47-3</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoe salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Shamokin, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Michael Durst (D)</b>		14. MOTHER'S MAIDEN NAME <b>Marie E. (?) (D)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>362-09-6515</b>	
17. INFORMANT <b>VA Hospital Records, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Bronchogenic carcinoma of left lung</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1-2 weeks</b> <b>1-2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>Sept. 19</b> , 19 <b>66</b> to <b>Nov. 17</b> , 19 <b>66</b> , that the deceased died on <b>Nov. 17</b> , 19 <b>66</b> , and that death occurred at <b>9:15 am</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>J. R. Garcia, M.D.</b>		22b. DATE SIGNED <b>11-17-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. R. GARCIA, M.D.</b>		22d. ADDRESS <b>VAH, Perry Point, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal-Burial</b>		23b. DATE THEREOF <b>11/22/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>	
24. FUNERAL DIRECTOR <b>W. W. Chambers Funeral Home, Washington, DC</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 22 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
15509					15509				
1. PLACE OF DEATH a. COUNTY CECIL					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DEL.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEWARK				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) UNION HOSPITAL					d. STREET ADDRESS 74 E. PARK PLACE				
3. NAME OF DECEASED (Type or print) CAROLENE Carol Jean					4. DATE OF DEATH November 3 1966				
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/1/36		9. AGE (In years last birthday) 29 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE CITY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM H. MILLER					14. MOTHER'S MAIDEN NAME CAROLYN GULOTT				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO					16. SOCIAL SECURITY NO. NONE		17. INFORMANT JAMES A. FERGUSON		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Pathy 4222 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus with acidosis. Pulmonary abscess					INTERVAL BETWEEN DEATH AND DEATH UNKNOWN				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
19									
21. I certify that (I) (this hospital) attended the deceased from 3 Nov, 1966, to 3 Nov, 1966, that (I) (we) last saw the deceased alive on 3 Nov, 1966, and that death occurred at 12:15 PM, from the causes and on the date stated above.									
22a. SIGNATURE Wallace Obenshain					22b. DATE SIGNED 5 Nov 66				
22c. PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D.					22d. ADDRESS Cecilton, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/7/66		23c. NAME OF CEMETERY OR CREMATORY OAK LAWN		23d. LOCATION (City, town or county) (State) BALTO MD.			
24. FUNERAL DIRECTOR PIPPIN FUNERAL HOME					25a. REC'D BY REGISTRAR DATE NOV 9 1966				
25b. REGISTRAR'S SIGNATURE J Charles Judge									

15510

15510

CERTIFICATE OF DEATH

UNITED STATES DEPARTMENT OF HEALTH

STATISTICS DIVISION AND RECORDS SECTION

U.S. GOVERNMENT PRINTING OFFICE

WASHINGTON, D.C. 20540

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15510

CERTIFICATE OF DEATH

15510

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. LENGTH OF STAY IN 1b <u>1 Hr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>UNION HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John FLETCHER Ford</u>		4. DATE OF DEATH Month Day Year <u>11 23 19 66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/24/03</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>NORTH EAST, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH FORD</u>		14. MOTHER'S MAIDEN NAME <u>NO INFO.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>109-12-4488</u>	
17. INFORMANT <u>EDWIN E. FORD</u>		Address <u>108 HILLTOP RD BALT. 25, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.2</u> DUE TO <u>Acute Cardiac Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Edema</u> DUE TO (c) <u>Myocarditis, Asthma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-Day</u> <u>2-Weeks</u> <u>1-Year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the doctor) attended the deceased from <u>11/22/</u> , 19 <u>66</u> to <u>11/23/</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>11/23/</u> , 19 <u>66</u> and that death occurred at <u>8 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>James L. Johnson</u>		22b. DATE SIGNED <u>11/25/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>James L. Johnson M.D.</u>		22d. ADDRESS <u>245 East High St., Elkton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/26/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>NORTH EAST</u>		23d. LOCATION (City or Town) (County) (State) <u>NORTH EAST MD. CECIL</u>	
24. FUNERAL DIRECTOR <u>PIPPIN FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>NOV 28 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

15511

15511

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN 1b <u>1 wk</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Union Hospital of Cecil County</u>				d. STREET ADDRESS <u>Childs</u> <u>07-1</u>			
3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>B.</u> Last <u>Gallagher</u>				4. DATE OF DEATH Month <u>November</u> Day <u>28</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 9, 1907</u>	
9. AGE (in years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postmaster</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Government</u>			
13. FATHER'S NAME <u>James H. Biggar</u>				14. MOTHER'S MAIDEN NAME <u>Sally Williams</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mr. A. Harlan Gallagher, Elkton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Emphysema arteriosclerotic Cardiovascular disease and premature senility</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 25, 1966</u> , to <u>Nov. 28, 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov. 28, 1966</u> , and that death occurred at <u>11:20 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>S. Ralph Andrews, Jr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/1/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>S. RALPH ANDREWS, JR. M.D.</u>				22d. ADDRESS <u>Elkton, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov 30, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Leeds Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Cecil County, Md.</u>	
24. FUNERAL DIRECTOR <u>Ralph E. Hicks</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
25c. ADDRESS <u>Hicks Home for Funerals, Elkton, Maryland</u>				DATE <u>DEC 7 1966</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
15512					15512				
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE				
Cecil MARYLAND					Md. Cecil				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Elkton					North East 07.1				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Union Hosp.					R.F.D. # 1				
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH		Month Day Year	
Alexander Norris Gilbert						Nov. 20		19 66	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8-29-1902		64 yrs.		Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Laborer Gen.			Del-Mar Chem. Co. Virginia			U.S.A.			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Russell R. Gilbert					Virginia Shelton				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No			218-07-0974		Mrs. Albert Shoeman		Rising Sun, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRAIN METASTASES 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA LEFT LUNG. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1963, 19, to 20 Nov, 1966, that (I) (we) last saw the deceased alive on 19 Nov 1966, and that death occurred at 7 PM, from the causes and on the date stated above.									
22a. SIGNATURE Robert L. Gray					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 21 Nov 1966
22c. PHYSICIAN'S NAME (Type) Robert L. Gray					22d. ADDRESS ELKTON MEDICAL PARK ELKTON				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)		
Burial			11-23-66		Brookview Cem.		Rising Sun, Md.		
24a. FUNERAL DIRECTOR Charles Judge					25a. REC'D BY REGISTRAR DATE NOV 23 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

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Alexander

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White

Wife

Belmont Green, Co. Virginia

Gen.

Laborer

Virginia Shelton

Rebecca R. Gilbert

18-07-07

Albert Chapman, Rising Sun, Md.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items 23c, 23d Film G383 12/7/66 mn

15513

CERTIFICATE OF DEATH

15513

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Chester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville</b>		c. LENGTH OF STAY IN 1b <b>1 yr, 9 mo</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxford</b>		75-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VA Hospital, Perry Point, Md.</b>		d. STREET ADDRESS <b>Box 114</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Harry M. Grason</b>		4. DATE OF DEATH Month Day Year <b>November 26 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-30-88</b>
9. AGE (In years lost birthday) yrs. <b>78</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mill hand</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Chester, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Mortimer B. Grason (Deceased)</b>		14. MOTHER'S MAIDEN NAME <b>Hattie Jackson (Deceased)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>184-09-0136</b>	
17. INFORMANT <b>VA Hospital records, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis. Osteomyelitis right tibia. Secondary anemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 18, 19 65</b> , to <b>Nov. 26, 19 66</b> , and that death occurred at <b>7:55 P.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Alfred G. Gillis</b>		22b. DATE SIGNED <b>11-27-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Alfred G. Gillis</b>		22d. ADDRESS <b>VAH Perry Point, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>Nov. 30, 19 66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Latrobe Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Oxford, Chester, Pa.</b>	
24. FUNERAL DIRECTOR <b>James H. Davis, 86 Penn St., Oxford, Pa.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>NOV 30 1966</b>	

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**15514**

**CERTIFICATE OF DEATH**

**15514**

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville</b> c. LENGTH OF STAY IN <sup>h</sup> <b>25 yrs, 7 mos., 5 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VA Hospital, Perry Point, Md.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2341 Loretta Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Oliver</b> Middle <b>Gross</b> Last <b>Gross</b>				4. DATE OF DEATH Month <b>November</b> Day <b>28</b> Year <b>1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/25/87</b>		9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months <b>30</b> Days <b>4</b>	IF UNDER 24 HRS. Hours <b>4</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Oysterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Oyster</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Calvert County, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Frank Gross</b>				14. MOTHER'S MAIDEN NAME <b>Sidney Johnson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>218-18-7863</b>		17. INFORMANT Address <b>VA Hospital Records, Perry Point, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary infarction, lower lobe, right lung</b> <b>465X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Massive pulmonary embolus, sudden</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) <del>the deceased</del> died from <b>4/23/1941</b> to <b>11/28/1966</b> , <del>and that death occurred at</del> <b>11:10pm</b> on <b>11/28/1966</b> from causes and on the date stated above.							22b. DATE SIGNED <b>11-29-66</b>
22a. SIGNATURE <i>S. Goldgraben</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) <b>S. GOLDGRABEN, M.D.</b>				22d. ADDRESS <b>VA Hospital, Perry Point, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>12-5, 66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. John C. Cem</b>		23d. LOCATION (City or Town) (County) (State) <b>Lusby Calvert Md.</b>	
24. FUNERAL DIRECTOR <i>Pinkney Sewell</i> ADDRESS <b>Maryland</b>				25a. REC'D BY REGISTRAR <b>DEC 7 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15515

CERTIFICATE OF DEATH

15515

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Manassas</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Manassas</b> d. STREET ADDRESS <b>556 Centerville Road, Lot 95</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES WILLIAM HALL</b>		4. DATE OF DEATH Month Day Year <b>November 16 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-25-12</b>
9. AGE (In years last birthday) <b>54</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, DC</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward S. Hall (D)</b>		14. MOTHER'S MAIDEN NAME <b>Margie M. Purcell (L)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>578-12-2104</b>	
17. INFORMANT <b>VA Hospital Records, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchopneumonia, Bilateral</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		INTERVAL BETWEEN ONSET AND DEATH <b>8-10 hrs</b> <b>Unknown</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>November 15, 1966</b> , to <b>November 16, 1966</b> , and that death occurred at <b>6:45 pm</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Balbir Singh M.D.</b>		22b. DATE SIGNED <b>11-17-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>BALBIR SINGH, M.D.</b>		22d. ADDRESS <b>VA Hospital, Perry Point, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>21 NOV. 66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>Arlington Funeral Home</b> by <b>C. N. CRAIG</b>		25a. REC'D BY REGISTRAR <b>Nov 21 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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Case 1:20-cv-00001-UNA Document 1-1 Filed 01/20/21 Page 1 of 1

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

15516

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15516

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. LENGTH OF STAY IN 1b <b>Port Deposit-rural</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Port Deposit</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>FRED</b> First Middle Last <b>Fred Hampton Hayes</b>				4. DATE OF DEATH Month Day Year <b>11 25 19 66</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/19/1913</b>	9. AGE (In years last birthday) <b>52</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Town of P. D.</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Shade Hayes</b>				14. MOTHER'S MAIDEN NAME <b>Louie Jane Brooks</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>223-12-7427</b>		17. INFORMANT Address <b>Mrs. Frances Hayes, Port Deposit, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wounds of chest and face</b> <b>919.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) <b>shot while hunting</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>4:30</b> <del>XX</del> p.m. <b>11 25 19 66</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>woods</b>		20f. (City or town) (County) (State) <b>Port Deposit Cecil Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <b>Perryville, Md.</b>			
22. DATE SIGNED <b>11/26/66</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/29/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hopewell Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Port Deposit, Cecil, Md.</b>	
24. FUNERAL DIRECTOR <b>Lee C. Peterson</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 1 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File (pages) 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15518

15518

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 of 3 to be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or interment, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
15517													
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton							
c. LENGTH OF STAY IN 1b 11 Days						d. STREET ADDRESS 143 East Main Street							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) ETTA A. HUNT						4. DATE OF DEATH November 23, 19 66							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 4, 1914		9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months Days			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Teaching		11. BIRTHPLACE (County & State, or foreign country) Anderson County, S. C.		12. CITIZEN OF WHAT COUNTRY? USA		10. IF UNDER 24 HRS. Hours Min.					
13. FATHER'S NAME J. M. Alexander						14. MOTHER'S MAIDEN NAME Etta Bell							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. 262-38-4080							
17. INFORMANT Mrs. Martha A. Riley, Seneca, S. C.						Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of the liver 5810 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Nov. 11, 1966, to Nov. 23, 1966, that (I) (we) last saw the deceased alive on Nov. 22, 1966, and that death occurred at 5:50 A.M. from the causes and on the date stated above.													
22a. SIGNATURE S. Ralph Andrews, Jr. M.D.						22b. DATE SIGNED 11/23/66							
22c. PHYSICIAN'S NAME (Type) S. RALPH ANDREWS JR.						22d. ADDRESS 233 E Main St, Elkton, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 25, 1966		23c. NAME OF CEMETERY OR CREMATORY Mountain View Cem.		23d. LOCATION (City, town or county) Seneca, South Carolina (State)							
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME						25. REC'D BY REGISTRAR DATE Nov 25 1966		25b. REGISTRAR'S SIGNATURE Charles Judge					

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Nov 22 1904

Wm. J. Anderson  
222 E. Main St. Elbert, Colorado

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15518

## CERTIFICATE OF DEATH

15518

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East</b> c. LENGTH OF STAY IN 1b <b>2 yrs.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>16 Church St.</b>		d. STREET ADDRESS <b>18 Church St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JESSE</b> Middle <b>GEORGE</b> Last <b>HURT</b>		4. DATE OF DEATH Month <b>November</b> Day <b>8</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 23, 1906</b>
9. AGE (In years last birthday) <b>59</b>		10. IF UNDER 1 YEAR Months <b>59</b> Days <b>59</b> Hours <b>59</b> Min. <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hospital Aid</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>V.A. Hospital</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Hinton, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wash Hurt</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW 2</b>		16. SOCIAL SECURITY NO. <b>233-14-3966</b>	
17. INFORMANT <b>Mrs. Carol J. Hollenbaugh</b>		Address <b>18 Church St. North East, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion with Myocardial Infarction</b> DUE TO (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) <b>14 months.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>9/19</b> , 19 <b>66</b> , to <b>11/8</b> , 19 <b>66</b> , that (1) (we) last saw the deceased alive on <b>10/8</b> , 19 <b>66</b> , and that death occurred at <b>12:30 A.M.</b> from causes on and on the date stated above.			
22a. SIGNATURE <b>Klaus H. Huebner</b>		22b. DATE SIGNED <b>11/8/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>KLAUS H. HUEBNER</b>		22d. ADDRESS <b>NORTH EAST, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/11/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Union Cecil Maryland</b>
24. FUNERAL DIRECTOR <b>Grant Funeral Home</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>NOV 10 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

1 (M)

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

15519

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15519

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>1/2 hour</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Elkton</u>		07.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>		d. STREET ADDRESS <u>Box 208, R.D. 5</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ned</u> Middle <u>Keys</u> Last <u>Keys</u>		4. DATE OF DEATH Month <u>11</u> Day <u>21</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-27-27</u>
9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Mm. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mushroom Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lee Keys</u>		14. MOTHER'S MAIDEN NAME <u>Ethel Oliver</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>155-20-6944</u>	
17. INFORMANT <u>Mrs. Ida Keys, R.D. 5, Elkton, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John M. Byers, M.D.</u> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Elkton, Md.</u>	
22. DATE SIGNED <u>11-21-66</u> <u>Elkton, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/25/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Jones Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>New River, Ashe Co. N.C.</u>	
24. FUNERAL DIRECTOR <u>Hicks Home for Funerals, Elkton, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 7 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>James J. Judge</u>			

15519

15519

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
SM 1/63

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>CECIL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EARLEVILLE RURAL LIFE</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EARLEVILLE RURAL ONI</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDITH KATHERIN KNOCK</u>		4. DATE OF DEATH Month Day Year <u>11 - 7 1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>04-27-1900</u>
9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>GEORGE W. COX</u>		14. MOTHER'S MAIDEN NAME <u>ELLA V. HUDSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-38-0391</u>	
17. INFORMANT <u>EDWARD FELLOWS</u>		Address <u>CECILTON 46</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLISM</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>FEMORAL CLOT</u> DUE TO (c) <u>FALL</u> INTERVAL BETWEEN ONSET AND DEATH <u>15 MINUTES</u> <u>3 DAYS</u> <u>3 DAYS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>FELL DOWNSTAIRS AT HOME 11/4/66</u>	
20c. TIME OF INJURY Month, Day, Year <u>2:30 p.m. 11/4 1966</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HOME</u>	20f. (City or town) (County) (State) <u>RURAL EARLEVILLE MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Henry V. Davis</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>HENRY V. DAVIS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>11/7/66</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11/10/66</u>	22c. NAME OF CEMETERY OR CREMATORY <u>JOHNTOWN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>EARLEVILLE, CECIL CO MD.</u>
23. FUNERAL DIRECTOR <u>Edward Fellows</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 10 1966</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

15520

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*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page]*

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# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VA 15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15521

15522

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Hartford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Candiff</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Pearl Marie McCallister</b> First Middle Last		4. DATE OF DEATH <b>11 - 14 19 66</b> Month Day Year	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-24-02</b> 9. AGE (In years last birthday) <b>64</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Cannery worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Canning</b>	
11. BIRTHPLACE (State or foreign country) <b>Ta.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William M. Sechnist</b>		14. MOTHER'S MAIDEN NAME <b>Ada Garrine</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>166-12-5214</b>	
17. INFORMANT <b>Williams, McCallister, Candiff, Md.</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>Immed.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John M. Byers, M.D.</b> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED <b>11-14-66</b> <b>Elkton Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>Nov. 17, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GUINSTON</b>	23d. LOCATION (City or Town) (County) (State) <b>BROOEVILLE, YORK CO., PA.</b>
24. FUNERAL DIRECTOR <b>John H. Harkins, DELTA, PA.</b> ADDRESS		25a. REC'D BY REGISTRAR <b>NOV 17 1966</b> DATE	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION

12233

OFFICE OF THE ATTORNEY GENERAL

12234



1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

15522

15523

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Cecil</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cecilton Rural</b> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cecilton.</b> d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>EDGAR C. McCOY</b>			<b>4. DATE OF DEATH</b> Month Day Year <b>November 27, 19 66</b>				
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>April, 8, 1897</b>	<b>9. AGE</b> (In years last birthday) <b>69</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Auto Mechanic Ret.</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Automobile</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Md.</b>			
<b>13. FATHER'S NAME</b> <b>Wilmer W. McCoy</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Cora Carter</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No.</b> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>217-03-1288</b>	<b>17. INFORMANT</b> Address <b>Mrs. Susie B. McCoy, Cecilton, Md. 21913</b>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pyelonephritis</b> 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 mos</b>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <b>Cerebral thrombosis secondary to Cerebral arteriosclerosis</b>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Dec 1</b> , 19 <b>62</b> , to <b>27 Nov</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>27 Nov</b> 19 <b>66</b> , and that death occurred at <b>6:30 PM</b> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>Wallace Obenshain</b> M.D.				<b>22b. DATE SIGNED</b> <b>29 Nov 66</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Wallace Obenshain, M.D.</b>				<b>22d. ADDRESS</b> <b>Cecilton, Md. 21913</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Dec. 1, 1966</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Bethel Cemetery.</b>			
<b>24. FUNERAL DIRECTOR</b> <b>Edward Fellows,</b>		<b>ADDRESS</b> <b>Millington, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>DEC 2 1966</b> <i>Charles Judge</i>			
<b>23d. LOCATION (City, town or county) (State)</b> <b>Chesapeake City, CecilCo; Md.</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**15523** **CERTIFICATE OF DEATH** **15524**

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Elkton</b> c. LENGTH OF STAY IN 1b <b>1 hr.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Union Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Delaware</b> b. COUNTY <b>N.C.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Newark</b> d. STREET ADDRESS <b>R.D. #2 Elkton, Md.</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>John B. McDaniel</b>		4. DATE OF DEATH <b>11-22-66</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-2-1901</b>		9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) <b>New Castle, Dela.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>George McDaniel</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Eliz. Dillon</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>221-22-6498</b>				17. INFORMANT <b>Josephine A. McDaniel</b>				Address <b>Same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO (b) <b>Hypertensive and Arteriosclerotic -</b> cause (a), stating the underlying cause last. (c) <b>Coronary artery disease.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Gout</b>														INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>3 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Aug</b> , 1966, to <b>Nov 22</b> , 1966, that (I) (we) last saw the deceased alive on <b>11-21</b> 1966, and that death occurred at <b>1:45</b> A.M. from the causes and on the date stated above.															
22a. SIGNATURE <b>Williford Eppes</b>										22b. DATE SIGNED <b>11-23-66</b>					
22c. PHYSICIAN'S NAME (Type) <b>Williford Eppes M.D.</b>										22d. ADDRESS <b>Medical Bldg. Main St, Newark, Dela.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>11-25-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Chesapeake City, Md.</b>							
24. FUNERAL DIRECTOR <b>William J. Warwick</b>				25a. REC'D BY REGISTRAR <b>DATE NOV 28 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									

62261

89281

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

15524

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15525

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DEL</u> b. COUNTY <u>NEW CASTLE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>		c. LENGTH OF STAY IN 1b <u>—</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SASSAFRAS RIVER</u>		d. STREET ADDRESS <u>140 DEVONSHIRE Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>CHESTER ALLEN MELLINGER JR</u>		4. DATE OF DEATH <u>NOVEMBER 4, 1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 23, 1924</u>
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>du Pont Co</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ENG</u>	
11. BIRTHPLACE (State or foreign country) <u>DEL</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>C. ALLEN MELLINGER SR.</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE ARMSTRONG</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>222-10-6858</u>	
17. INFORMANT <u>W. E. LYNCH - WILM. DEL</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immed.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None known</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell overboard during rough weather</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m. 3:30</u> p.m. <u>11-4-1966</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Amity Ford River</u>		20f. (City or town) <u>SassafRAS Riv.</u> (County) <u>Cecil</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Tillman D. Johnson</u> M.D.		22. DATE SIGNED <u>11-8-66</u>	
EXAMINER'S NAME (Type) <u>Tillman D. Johnson</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>123 Singler Ave, Elkton</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/10/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GRACE LAWN</u>		23d. LOCATION (City or Town) <u>WILM. N. CASTLE DEL</u> (County) (State)	
24. FUNERAL DIRECTOR <u>DIPPIN/FUNERAL HOME</u> ADDRESS <u>ELKTON MD</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>NOV 14 1966</u>			

75761

8221



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
15525 CERTIFICATE OF DEATH 15526										
1. PLACE OF DEATH a. COUNTY <u>Cecil</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>			c. LENGTH OF STAY IN lb <u>1 1/2 Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>			d. STREET ADDRESS <u>39 High Street</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pratt Nursing Home</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E.</u> Last <u>Miller</u>					4. DATE OF DEATH Month <u>Nov.</u> Day <u>23</u> Year <u>1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cau.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 21, 1875</u>		9. AGE (In years last birthday) <u>91</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Enoch K. Miller</u>					14. MOTHER'S MAIDEN NAME <u>Fannie Jeffreys</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Emma E. Miljer, Port Deposit, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>422.1</u> DUE TO (b) <u>Arteriosclerosis C.V. KD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>-----</u>								INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>10 pm</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-----</u>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>-----</u> e.m. <u>19</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 2, 1958</u> to <u>11-23</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11-23</u> , 19 <u>66</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.										
22a. SIGNATURE <u>G. H. Richards M.D.</u>					22b. DATE SIGNED <u>11/23/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>G. H. Richards M.D.</u>					22d. ADDRESS <u>Port Deposit, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>11-27-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary Anns Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>North East, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson &amp; Son</u>					ADDRESS <u>Perryville, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 1 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

15258

CERTIFICATE OF DEATH

15258

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit, then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15526

CERTIFICATE OF DEATH

15527

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>				c. LENGTH OF STAY in 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Craigtown Road</u>				d. STREET ADDRESS <u>07.1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sara E. Mitchell</u>				4. DATE OF DEATH Month Day Year <u>Nov 27 19 66</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Can.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 15, 1872</u>		9. AGE (In years lost birthday) yrs. <u>94</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Colgain</u>				14. MOTHER'S MAIDEN NAME <u>Esther Sparks</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-54-2715</u>		17. INFORMANT Address <u>Mrs. Elsie Bailey, Port Deposit, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Old Age</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 mo</u> <u>3 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>55</u> , to <u>Nov 27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov 15</u> , 19 <u>66</u> , and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE <u>Dudley Phillips MD</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/28/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dudley Phillips MD</u>				22d. ADDRESS <u>Port Deposit Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-30-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greensboro Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Greensboro Md</u>	
24. FUNERAL DIRECTOR <u>Lee A. Patterson &amp; Son, Perryville, Md.</u>				25a. REC'D BY REGISTRAR <u>DEC 1 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

15253

CERTIFICATE OF DEATH

15253



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15527

CERTIFICATE OF DEATH

15528

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Delaware</b> b. COUNTY <b>Wilmington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville</b>		c. LENGTH OF STAY IN 1b <b>2 months</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frenchtown Road</b>		d. STREET ADDRESS <b>1915 Marsh Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Edith</b> Middle <b>M.</b> Last <b>Moore</b>		4. DATE OF DEATH Month <b>November</b> Day <b>27</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cau.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/26/1901</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months <b>65</b> Days <b>65</b> Hours <b>65</b> Min. <b>65</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Delaware Hospital</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Marshall</b>		14. MOTHER'S MAIDEN NAME <b>Winifred Robinson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>221-14-9945</b>	
17. INFORMANT <b>Mrs. Betty Thompson</b>		Address <b>Perryville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Convict B/ on M. taken to live</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8-17</b> , 19 <b>66</b> , to <b>11-27</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>11-27</b> , 19 <b>66</b> , and that death occurred at <b>4:30</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>G. H. Richards, Jr.</b>		22b. DATE SIGNED <b>11-28-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. H. Richards, Jr.</b>		22d. ADDRESS <b>Port Deposit, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 29, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Port Deposit, Cecil, Md.</b>	
24. FUNERAL DIRECTOR <b>See Peterson &amp; Son</b>		25a. REC'D BY REGISTRAR <b>Perryville, Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		DATE <b>DEC 1 1966</b>	

12258

STATE OF NEW YORK

12258





**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**15528** **15529**  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Cecil.</b> <span style="float: right;">MARYLAND</span>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> <span style="float: right;">b. COUNTY <b>Cecil</b></span>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cecilton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cecilton</b> <span style="float: right;">07-1</span>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM T. PARKS.</b>		4. DATE OF DEATH Month <b>November</b> Day <b>27</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 6, 1887</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Farmer</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Farming.</b>	
12. BIRTHPLACE (County & State, or foreign country) <b>Md.</b>		13. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. FATHER'S NAME <b>William G. Parks.</b>		15. MOTHER'S MAIDEN NAME <b>Della Durell</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		17. SOCIAL SECURITY NO. 17. INFORMANT <b>George Parks,</b> <span style="float: right;">Address <b>Chesapeake City, Md. R.D.</b></span>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Prob. coronary occlusion and massive infarction</b>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 1</b> , 19 <b>66</b> , to <b>27 Nov</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>27 Nov</b> 19 <b>66</b> , and that death occurred at <b>6 a.m.</b> from the causes and on the date stated above.			
22a. SIGNATURE <i>Wallace Obenshain</i>		22b. DATE SIGNED <b>29 Nov 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wallace Obenshain, M.D.</b>		22d. ADDRESS <b>Cecilton, Md. 21913</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov. 29, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Johntown Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Earleville, Cecil Co; Md.</b>
24. FUNERAL DIRECTOR <b>Edward Fellows,</b> <span style="float: right;">ADDRESS <b>Millington, Md.</b></span>		25a. REC'D BY REGISTRAR DATE <b>DEC 2 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

15529

15530

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cecilton</b>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <b>071</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Union Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>ALMA</b> Middle <b>E.</b> Last <b>PEARCE</b>		4. DATE OF DEATH		Month <b>November</b> Day <b>28</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 23, 1889</b>	9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months <b>07</b> Days <b>1</b>		IF UNDER 24 HRS. Hours <b>00</b> Min. <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joshua Reed.</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Clark.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Andrew Jackson Pearce, Cecilton, Md. 21913</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Atrophy of right leg due to embolus of femoral artery</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1 Aug</b> , 19 <b>66</b> , to <b>28 Nov</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>29 Nov</b> , 19 <b>66</b> and that death occurred at <b>10:00 PM</b> on the causes and on the date stated above.							
22a. SIGNATURE <b>Wallace Obenshain</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1 Dec 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wallace Obenshain, M.D.</b>				22d. ADDRESS <b>Cecilton, Md. 21913</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 2, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Chesapeake City, Md.</b>	
24. FUNERAL DIRECTOR <b>Edward Fellows.</b>				ADDRESS <b>Millington, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 5 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Union Medical

1955

November

1955

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December 22, 1955

December 22, 1955

San Jose

San Jose

Elizabeth City

Elizabeth City

Andrew Jackson House, Cecil, Md.

No.

Generalized arteriosclerosis

History of right leg due to arterial insufficiency

20 Nov 55  
10:00 PM

20 Nov 55

Cecil, Md. 21512

William O. Smith, M.D.

The Queen City

Bellevue Hospital

Dec. 1, 1955

Chief

Washington, Md.

Chief

15530

# CERTIFICATE OF DEATH

15531

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>51 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VA Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Clayton</b> Middle <b>D.</b> Last <b>PFAFF</b>		4. DATE OF DEATH Month <b>November</b> Day <b>9</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>12 3 90</b>
9. AGE (In years lost birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>15</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer-Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Frostburg, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Conrad Pfaff (Deceased)</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Doring (Deceased)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>220-10-21-04</b>	
17. INFORMANT Address <b>VA Hospital Records - Perry Point, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> <b>1621</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bronchogenic carcinoma of both lungs</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>6 months</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>IRINA</b> (this hospital) attended the deceased from <b>9-19-66</b> , 19__, to <b>11-9-66</b> , 19__, and that death occurred at <b>4pm</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Irina Reus</b>		22b. DATE SIGNED <b>11 10 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>IRINA REUS, M.D.</b>		22d. ADDRESS <b>VAH PERRY POINT, MD.</b>	
23a. BURIAL CREMATION <b>REMOVED</b>	23b. DATE THEREOF <b>11 10 66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Deer Creek Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Darlington, Maryland</b>
24. FUNERAL DIRECTOR <b>PATTERSON FUNERAL HOME - Perryville, Md.</b>		25. REC'D BY REGISTRAR <b>NOV 15 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15531

## CERTIFICATE OF DEATH

15532

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN 1b <b>51-3</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Chicago</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chicago</b> d. STREET ADDRESS <b>504 N. Hamlin Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CARL J. POORE</b>		4. DATE OF DEATH Month Day Year <b>November 16 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>4-22-08</b>
9. AGE (In years last birthday) <b>58</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Kingsport, Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert Poore (D)</b>		14. MOTHER'S MAIDEN NAME <b>Mattie Kane (D)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>341-09-9356</b>	
17. INFORMANT Address <b>VA Hospital Records, Perry Point, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration pneumonia</b> <b>5271</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic pulmonary emphysema, severe</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerotic Heart Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3-4 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>10</b> (this hospital) attended the deceased from <b>January 7, 19 66</b> , to <b>November 16, 1966</b> , that (b) (we) last saw the deceased on <b>XXXXXXX</b> and that death occurred on <b>9:15 am</b> from causes and on the date stated above.			
22a. SIGNATURE <b>S. Goldgraben</b>		22b. DATE SIGNED <b>11-16-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>S. GOLDGRABEN, M.D.</b>		22d. ADDRESS <b>VA Hospital, Perry Point, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE THEREOF <b>11-17-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gilpin Manor Mem. Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Elhton, Maryland</b>
24. FUNERAL DIRECTOR <b>Lee C. Patterson &amp; Son, Perryville, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 21 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Veterans Administration Hospital

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VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15532

CERTIFICATE OF DEATH

15533

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville</b>		c. LENGTH OF STAY IN 1b <b>17 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Harford</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VA Hospital, Perry Point, Md.</b>				e. STREET ADDRESS <b>Box 14</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>George D. Price</b>			4. DATE OF DEATH Month Day Year <b>November 20 1966</b>						
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-29-90</b>		9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inspector</b>		10b. KIND OF BUSINESS, OR INDUSTRY <b>U.S. Govt. Building</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Henry Price</b>				14. MOTHER'S MAIDEN NAME <b>Laura Reese</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WWI</b>		16. SOCIAL SECURITY NO. <b>220-20-7571</b>		17. INFORMANT Address <b>VA Hospital Rec ords, Perry Point, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the lip with metastases</b> 1409 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonia</b> DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs</b> <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>VA 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from <b>11/3/</b> , 1966, to <b>11/20/</b> , 1966, <del>and that death occurred at 5:50 PM, from causes and on the date stated above.</del>									
22a. SIGNATURE <i>S. Goldgraben</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11-20-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>S. GOLDGRABEN, M.D.</b>				22d. ADDRESS <b>VA Hospital, Perry Point, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 23, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cokesbury Memorial Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Abingdon Harford Md</b>			
24. FUNERAL DIRECTOR ADDRESS <b>McComas Funeral Home, Abingdon, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 22 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

MEDICAL CERTIFICATION

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VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15533

15534

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF TIME IN TOWN <b>4 yrs 9 mos</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillcrest Heights</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>2509 Jameson Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>PAUL</b>		First Middle Last <b>PAUL SAN LUIS</b>		4. DATE OF DEATH <b>November 8 19 66</b>		Month Day Year	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-27-09</b>	
9. AGE (In years last birthday) <b>57</b>		10. UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <b>Phillipine Islands</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Poncians San Luis (D)</b>		14. MOTHER'S MAIDEN NAME <b>Victoria (Unk) (D)</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>PL 28 3-9-27/1-21-51 220-54-6747 VA Hospital Records, Perry Point, Md.</b>			
16. SOCIAL SECURITY NO. <b>220-54-6747</b>		17. INFORMANT <b>VA Hospital Records, Perry Point, Md.</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>493X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>February 7, 19 62</b> to <b>November 8, 19 66</b> , and that death occurred at <b>7:50 AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Balbir Singh</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11-8-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>BALBIR SINGH, M.D.</b>		22d. ADDRESS <b>VAH, Perry Point, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/12/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Ft. Meyer, Virginia</b>	
24. FUNERAL DIRECTOR <b>Patterson Funeral Home, Perryville, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 15 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

15534

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Patient's Name		Date of Birth	
JAMES EARL RAY		5-1-38	
Address		City	
2504 Jackson Street		Memphis, Tenn.	
Occupation		Status	
Unemployed		Single	
Referral Source		Referral Date	
Veterans Administration Hospital		11-8-66	
Referral Physician		Referral Hospital	
Dr. J. H. Jones		Veterans Administration Hospital	
Referral Diagnosis		Referral Date	
Psychosis		11-8-66	
Referral Treatment		Referral Hospital	
Medication		Therapy	
Haloperidol		Group Therapy	
Dosage		Frequency	
2 mg. tid		Daily	
Referral Notes		Referral Hospital	
Patient is a 28-year-old male, single, unemployed, with a history of psychosis. He was referred to the Veterans Administration Hospital for treatment.		11-8-66	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

15534

15535

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>			c. LENGTH OF STAY IN 1b <b>83 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>2819 14th St., N.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>LAURENCE ALEXANDER SAVOY</b>				4. DATE OF DEATH Month Day Year <b>November 14 19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-15-12</b>		9. AGE (In years last birthday) <b>54</b> yrs.	IF UNDER 1 YEAR Months Oys Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, DC</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Daniel Savoy (D)</b>				14. MOTHER'S MAIDEN NAME <b>Catherine (?) (D)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>579-05-5268</b>		17. INFORMANT Address <b>VA Hospital Records, Perry Point, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia bilateral severe</b> 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Esophagus</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>10-14 days</b> <b>5-10 Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>PA</b> (this hospital) attended the deceased from <b>August 23, 19 66</b> , to <b>November 14, 19 66</b> , that <b>(a) (two) last seen the deceased alive on xxxxxxxxxxxxxxxxxx</b> and that death occurred at <b>1:30 PM</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Joel Blancaflor</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11-15-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOEL BLANCAFLOR, M.D.</b>				22d. ADDRESS <b>VAH, Perry Point, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>11/18/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Orlinton National Orlinton</b>		23d. LOCATION (City or town) (County) (State) <b>2a</b>	
24. FUNERAL DIRECTOR <b>Bullock Funeral Home, Havre de Grace, Md.</b>				25a. REC'D BY REGISTRAR <b>NOV 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

15536

15535

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LAURENCE</b> First <b>MILLER</b> Middle <b>SIMMONS</b> Last		4. DATE OF DEATH Month <b>November</b> Day <b>29</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 5, 1913</b>
9. AGE (In years Last birthday) yrs. <b>53</b>		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Proof Technician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Cecil Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Simmons</b>		14. MOTHER'S MAIDEN NAME <b>Mary Dicks</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW 2</b>		16. SOCIAL SECURITY NO. <b>218-03-0593</b>	
17. INFORMANT <b>Mrs. Elizabeth E. Simmons</b>		Address <b>North East, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Recurrent Coronary Occlusion with Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Atherosclerosis</b> DUE TO (c) <b>-</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>17 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>-</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-</b>	20f. (City or town) (County) (State) <b>-</b>
21. I certify that (I) (this hospital) attended the deceased from <b>28 Dec</b> , 19 <b>65</b> , to <b>29 Nov</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>29 Nov</b> 19 <b>66</b> , and that death occurred at <b>5:54 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Klaus H. Huebner</b>		22b. DATE SIGNED <b>11/29/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Klaus H. Huebner</b>		22d. ADDRESS <b>Cecil Ave. North East, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/2/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Immaculate Conception</b>	23d. LOCATION (City or Town) (County) (State) <b>Cherry Hill Cecil Md.</b>
24. FUNERAL DIRECTOR <b>Grant Funeral Home</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>DEC 2 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15536

CERTIFICATE OF DEATH

15537

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u> c. LENGTH OF STAY IN 1b <u>07-1</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Richmond Hill Apt.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u> d. STREET ADDRESS <u>Richmond Hill Apt.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elmore G. Smith</u>		4. DATE OF DEATH Month Day Year <u>November 20, 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Can.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6-30-1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	9. AGE (In years lost birthday) <u>83</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel G. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Emma E. Morgan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>148-03-9174</u>	
17. INFORMANT <u>Mrs. Ada Smith, Perryville, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Old age</u> <u>293X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> to <u>1966</u> that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred on <u>20</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John D. Yun</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>JOHN D. YUN</u>		22d. ADDRESS <u>Home de Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-23-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Port Deposit, Md.</u>	
24. FUNERAL DIRECTOR <u>Lee A. Patterson &amp; Son, Perryville, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 28 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p><b>15537</b></p> </div> <div> <p><b>MARYLAND</b></p> <p><b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b></p> <p><b>CERTIFICATE OF DEATH</b></p> </div> <div> <p><b>15538</b></p> </div> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cecil</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> c. LENGTH OF STAY IN b. <u>2 wks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Union Hospital</u>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> d. STREET ADDRESS <u>229 Hollingsworth Manor</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) <u>KATHLEEN</u> <u>SMITH</u> First Middle Last					<b>4. DATE OF DEATH</b> <u>Nov. 4, 1966</u> Month Day Year						
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Jan. 28, 1934</u> Yrs.		<b>9. AGE</b> (In years last birthday) <u>32</u> IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Line Operator</u>					<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>R.M.R. Corp.</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		
<b>13. FATHER'S NAME</b> <u>Benjamin Justus</u>					<b>14. MOTHER'S MAIDEN NAME</b> <u>Eliza Smith</u>						
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)					<b>16. SOCIAL SECURITY NO.</b> <u>220-44-3577</u>					<b>17. INFORMANT</b> <u>Vernon Smith, Elkton, Md.</u> Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASPIRATION PNEUMONIA</u> (b) <u>RADIATION PERITONITIS</u> (c) <u>CANCER OF CERVIX</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1-2 HOURS</u> <u>2 months</u> <u>UNKNOWN</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).</b>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)					<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)						
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <u>19</u>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)				
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>10/21, 1966</u> <b>to</b> <u>11/3, 1966</u> <b>that (I) (we) last saw the deceased alive on</b> <u>11/2, 1966</u> , <b>and that death occurred at</b> <u>4:00 P.M.</u> , <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>J. R. Ross</u>					<b>22b. DATE SIGNED</b> <u>11/7/66</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>I. R. ROSS M.D.</u>				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>					<b>23b. DATE THEREOF</b> <u>11/7/66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>GILPIN MANOR MEMORIAL PARK, ELKTON, MD.</u>		<b>23d. LOCATION</b> (City, town or county) (State)		
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Hicks Home for Funerals, Elkton, Md.</u>					<b>25a. REC'D BY REGISTRAR</b> <u>NOV 18 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>				

MEDICAL CERTIFICATION

15538

CERTIFICATE OF DEATH

15537

*[Handwritten signature]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
15538 CERTIFICATE OF DEATH 15539									
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b 22 Years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital Of Cecil County					d. STREET ADDRESS 109 Milburn St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bessie			First Middle Last Sparks		4. DATE OF DEATH 11 10 19 66		Month Day Year		
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/13/95		9. AGE (In years last birthday) 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Goldsboro, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur John Rochester					14. MOTHER'S MAIDEN NAME Martha Tilghman				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Mildred Wilson, Chestertown, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Of Gastro-Intestinal Tract. 159X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH 7 Mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from May 12, 1966, to 11/10/ 1966, that (I) (we) last saw the deceased alive on 11/10/ 1966, and that death occurred at 1:15 M, from the causes and on the date stated above.									
22a. SIGNATURE James L. Johnson					ATTENDING PHYS. <input checked="" type="checkbox"/> M.O. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/11/66		
22c. PHYSICIAN'S NAME (Type) James L. Johnson M.D.					22d. ADDRESS 245 E. High Street, Elkton, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/14/66		23c. NAME OF CEMETERY OR CREMATORY Richneck Hall, Cemetery			23d. LOCATION (City, town or county) (State) Ewingtown Md.		
24. FUNERAL DIRECTOR ADDRESS Edward K. Bell 909 Poplar St.					25a. REC'D BY REGISTRAR NOV 17 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

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CENTRE OF THE

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15539

CERTIFICATE OF DEATH

15540

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Unknown</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville, Maryland</b>		c. LENGTH OF STAY IN 15- <b>5 yrs, 1 mo. / 16 days</b> d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eccles</b> <b>85.3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VA Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Stanich</b>		4. DATE OF DEATH Month Day Year <b>November 27 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1894</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <b>72</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coal miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>mining</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Yugoslavia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>217-54-9830</b>	
17. INFORMANT <b>VA Hospital Records - Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Tuberculous Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Miliary Tuberculosis of Lungs Advanced</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3-6 Mo.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Whole History of Tuberculosis 1952</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>VA 19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>XXXXXX</del> attended the deceased from <b>October 11, 1961</b> , to <b>11/27, 1966</b> , <del>XXXXXX</del> and that death occurred at <b>3:30 a.m.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Balbi Singh M.D.</b>		22b. DATE SIGNED <b>11 29 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>BALBI SINGH, M.D.</b>		22d. ADDRESS <b>VA Hospital, Perry Point, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE THEREOF <b>11 29 66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>PENNINGTON &amp; SON FUNERAL HOME-Havre deGrace, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 2 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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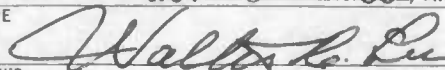
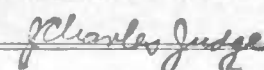
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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**15540** **CERTIFICATE OF DEATH** **15541**

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chesapeake City</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cecilton</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Morgan Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Elsie</b> Middle <b>L.S.</b> Last <b>Taylor</b>				4. DATE OF DEATH Month <b>November</b> Day <b>10</b> Year <b>1966</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 15, 1893</b>	9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Philadelphia, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Frazer</b>				14. MOTHER'S MATEEN NAME <b>Susan Groves.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>164-03-8520B</b>		17. INFORMANT <b>Davis Taylor,</b>		Address <b>Cecilton, Md, 21913</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> <b>170X</b> DUE TO <b>Cardiac Arrhythmias following</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CA of Breast operation</b> DUE TO (c) <b>Arteriosclerotic Cardiovascular Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>10 hrs.</b> <b>36 days.</b> <b>15 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 1961, to <b>Nov</b> , 1966, that (I) <del>last</del> saw the deceased alive on <b>Nov 8</b> 1966, and that death occurred <b>1:30 P.M.</b> from the causes and on the date stated above.							22b. DATE SIGNED
22a. SIGNATURE  22c. PHYSICIAN'S NAME (Type) <b>Walter H. Lee, M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22d. ADDRESS <b>206 S. Broad St; Middletown, Del.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov. 12, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fernwood Cemetery.</b>		23d. LOCATION (City, town or county) (State) <b>Landsdowne, Pa.</b>			
24. FUNERAL DIRECTOR <b>Edward Fellows,</b>				ADDRESS <b>Millington, Md. 21651</b>		25a. REC'D BY REGISTRAR <b>NOV 14 1966</b>	
				25b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Good

Good

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Taylor

Chair

June 12, 1962

Chair

Our Home

Housewife

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Good

101-00-82008 Davis Taylor, California, 12, 1962

Additional information  
added and/or  
of great interest

Additional information added and/or of great interest

*Handwritten signature*

100 A. Street St. Washington, Del.

100 A. Street St. Washington, Del.

100 A. Street St. Washington, Del.

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100 A. Street St. Washington, Del.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15541

CERTIFICATE OF DEATH

15542

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		c. LENGTH OF STAY IN 1b 67 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital, Perry Point, Maryland			d. STREET ADDRESS 5709 Chillum Heights Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Edward Joseph Tenly			4. DATE OF DEATH Month Day Year November 20 19 66		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 9-4-95		9. AGE (In years lost birthday) yrs. 71
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY Hauling		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME James Tenly			14. MOTHER'S MAIDEN NAME Alice Eggleston		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW I 579-03-1827		17. INFORMANT Address VA Hospital Records, Perry Point, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Bronchopneumonia DUE TO (b) Congestive heart failure DUE TO (c) Arteriosclerotic heart disease					INTERVAL BETWEEN ONSET AND DEATH 5-10 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (1) the hospital attended the deceased from 9-14-1966, to 11-20-1966, and that death occurred at 5:15 p.m. from causes and on the date stated above.					
22a. SIGNATURE S. Goldgraben		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 11-21-66	
22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, M.D.		22d. ADDRESS VAH, Perry Point, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/23/1966		23c. NAME OF CEMETERY OR CREMATORY Arlington National	
23d. LOCATION (City or Town) (County) (State) Arlington Virginia					
24. FUNERAL DIRECTOR Arthur Walters		ADDRESS Wash. DC		25a. REC'D BY REGISTRAR	
Takoma Park Funeral Home, 254 Carroll St., N.W.		DATE NOV 23 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15542

## CERTIFICATE OF DEATH

15543

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 33 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital Of Cecil County		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Henry Middle Van Den Heuvel Last		4. DATE OF DEATH Month 11 Day 28 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/3/89
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Elk Paper Co.	
11. BIRTHPLACE (County & State, or foreign country) Hay Springs, Nebraska		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Andrew Van Den Heuvel		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-05-3898	
17. INFORMANT Mrs. Marcella Dalgarn		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio- Sclerotic Cerebro Vascular DUE TO (c) Heart Disease			INTERVAL BETWEEN ONSET AND DEATH 10-Days 2-Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/28/1966, to 11/28/1966, that (I) (we) last saw the deceased alive on 10/28/1966, and that death occurred at 2:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE James L. Johnson		22b. DATE SIGNED 11/29/66	
22c. PHYSICIAN'S NAME (Type) James L. Johnson M.D.		22d. ADDRESS 245 E. High St., Elkton, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12/1/66	23c. NAME OF CEMETERY OR CREMATORY Immaculate Conception	23d. LOCATION (City or Town) (County) (State) Cherry Hill, Md.
24. FUNERAL DIRECTOR Hicks Home for Funerals, Elkton, Md.		25a. REC'D BY REGISTRAR DEC 7 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

523

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15543

CERTIFICATE OF DEATH

15544

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bainbridge</u>		c. LENGTH OF STAY IN 1b <u>1 hr. 48 min.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Station Hospital, U:SNTC</u>		d. STREET ADDRESS <u>Apartment D 9-1</u>	
3. NAME OF DECEASED (Type or print) First <u>Shawn</u> Middle <u>Allen</u> Last <u>VOLK</u>		4. DATE OF DEATH Month <u>November</u> Day <u>6</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 6, 1966</u>
9. AGE (In years last birthday) <u>1</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>48</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (County & State, or foreign country) <u>Cecil County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert Leroy VOLK</u>		14. MOTHER'S MAIDEN NAME <u>Brenda Kay HUDSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7547</u> DUE TO <u>Concurrent Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congenital Heart Disease</u> DUE TO (c) <u>Transposition of Great vessels &amp; Large VSD.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>6 November 1966</u> , to <u>6 Nov.</u> , 19 <u>66</u> that (I) <u>last</u> saw the deceased alive on <u>6 November 1966</u> , and that death occurred at <u>9:25</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Sol Rockenmacher</u>		22b. DATE SIGNED <u>11/7/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>SOL ROCKENMACHER LT MC USNR</u>		22d. ADDRESS <u>Station Hospital, USNTC, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9 November 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Nottingham Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Coloma Cecil Md.</u>
24. FUNERAL DIRECTOR <u>LEE A. PATTERSON &amp; SON, PERRYVILLE, MD</u>		25. REC'D BY REGISTRAR <u>NOV 15 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15544

## CERTIFICATE OF DEATH

15545

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN 1b <u>1 mo.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>				d. STREET ADDRESS <u>R.D.</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Miller</u> Last <u>Williams</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>26</u> Year <u>1966</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 9, 1909</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fortune Teller</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Uaigh Miller</u>				14. MOTHER'S MAIDEN NAME <u>Bolinka Miller</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If give war or dates of service) <u>  </u>		17. INFORMANT <u>Louis Williams, Elkton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANOXIA</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause } (b) <u>CARDIO-RESPIRATORY FAILURE</u> (a), stating the underlying cause last. } DUE TO (c) <u>CANCER OF THE LUNGS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 wks.</u> <u>8-10 wks.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> e.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>FEB.</u> 19 <u>66</u> , to <u>NOV. 26</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>NOV. 25</u> , 19 <u>66</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Rolando A. Majera, M.D.</u>				22b. DATE SIGNED <u>11/26/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Rolando A. Majera, M.D.</u>				22d. ADDRESS <u>105 East Main Street, Elkton, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/29/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Elizabeth, N.J.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Rich E. Hicks</u> Hicks Home for Funerals, Elkton, Md.				25a. REC'D BY REGISTRAR <u>DEC 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15542

15542



RECEIVED  
FEB 10 1964  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]  
[Illegible text follows, appearing to be a memorandum or report with several paragraphs of text that is mostly unreadable due to fading and bleed-through.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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(M)

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15545

CERTIFICATE OF DEATH

15546

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point, Md.</b> c. LENGTH OF STAY IN 1b <b>61 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VA Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2706 Miles Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Abraham WISE</b>		4. DATE OF DEATH Month Day Year <b>November 9 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12 2 89</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Abraham (Deceased)</b>		14. MOTHER'S MAIDEN NAME <b>Emma Crozier (Deceased)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>212-18-29-70</b>	
17. INFORMANT <b>VA Hospital Records - Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia with pulmonary edema</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive heart failure</b> DUE TO (c) <b>Arteriosclerotic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5-6 days</b> <b>-</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Carcinoma of prostate</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>45</b> (this hospital) attended the deceased from <b>4 22 66</b> , 19 <b>199-66</b> , 19 <b>199-66</b> , to <b>11 10 66</b> , 19 <b>199-66</b> , that <b>45</b> (myself) last saw the deceased alive on <b>11 10 66</b> , and that death occurred at <b>5:45 P.M.</b> from causes on and on the date stated above.			
22a. SIGNATURE <b>Balbair Singh M.D.</b>		22b. DATE SIGNED <b>11 10 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>BALBIR SINGH, M.D.</b>		22d. ADDRESS <b>VA Hospital - Perry Point, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>11 10 66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md</b>	
24. FUNERAL DIRECTOR <b>FRANKLIN W. SEITZ 814 W 36th St Balt Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 15 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

15258

CENTRAL OF PENN

15258

CELL

First found, 2. 21 days

intermediate

Initial

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overlook

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